

Family Planning Only Program telemedicine services offered during the COVID-19 outbreak

Telemedicine

What is telemedicine?

Telemedicine is when health care practitioners use HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology to deliver covered services that are within their scope of practice to a client at a site other than the site where the provider is located.

Can Family Planning Only providers use telemedicine for their patients?

Using telemedicine when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows agency clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The agency does not cover the following services as telemedicine:

- Email, audio only telephone, and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Purchase, rental, or repair of telemedicine equipment

Who is eligible for telemedicine?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telemedicine. The referring provider is responsible for determining and documenting that telemedicine is medically necessary. As a condition of payment, the client must be present and participating in the telemedicine visit. Clients under the Family Planning Only – Pregnancy Related program and the Family Planning Only program (formerly referred to as TAKE CHARGE) are eligible for telemedicine through fee-for-service.

When does HCA cover telemedicine?

The agency covers telemedicine when it is used to substitute for an in-person face-to-face, hands-on encounter for only those services specifically listed in this telemedicine section.

What are the documentation requirements?

The documentation requirements are listed under the evaluation and management (E/M) service which is based on key components listed in the CPT® manual. Providers must use either the 1995 or 1997 “Documentation guidelines for evaluation and management services” to determine the appropriate level of service.

Once the licensed practitioner chooses either the 1995 or 1997 guidelines, the licensed practitioner must use the same guidelines for the entire visit. Chart notes must contain documentation that justifies the level of service billed.

Documentation must:

- Be legible to be considered valid.
- Support the level of service billed.
- Support medical necessity for the diagnosis and service billed.
- Be authenticated by provider performing service with date and time.

Keys to documenting medical necessity to support Evaluation and Management service:

- Document all diagnoses managed during the visit.
- For each established diagnosis, specify if the patient's condition is stable, improved, worsening, etc.
- Document rationale for ordering diagnostic tests and procedures.
- Clearly describe management of the patient (e.g., prescription drugs, over the counter medication, surgery).

A provider must follow the CPT coding guidelines and their documentation must support the E&M level billed. While some of the text of CPT has been repeated in this billing guide, providers should refer to the CPT book for the complete descriptors for E/M services and instructions for selecting a level of service.

Documentation should also include:

- Verification that the service was provided via telemedicine
- The location of the client and a note of any medical personnel with the client
- The location of the provider
- The names and credentials (MD, ARNP, RN, PA, CNA, etc.) of all people involved in the telemedicine visit, and their role in the encounter at both the originating and distant sites

Originating site

What is an originating site?

An originating site is the physical location of the eligible agency client at the time the professional service is provided by a physician or practitioner through telemedicine. Approved originating sites are:

- Clinics
- Community mental health/chemical dependency settings
- Dental offices
- Federally qualified health centers (FQHC)
- Homes or any location determined appropriate by the individual receiving service
- Hospitals (inpatient and outpatient)
- Neurodevelopmental centers
- Physician or other health professional's offices
- Renal dialysis centers, except an independent renal dialysis center
- Rural health clinics (RHC)
- Schools
- Skilled nursing facilities

Is the originating site paid for telemedicine?

Yes. The originating site is paid an originating site facility fee per completed transmission for telemedicine services. The agency does not pay the originating site facility fee to the client in any setting.

How does the originating site bill the agency for the originating site facility fee?

- Hospital outpatient: When the originating site is a hospital outpatient agency, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive payment for the

originating site facility fee, outpatient hospital providers must bill revenue code 0780 on the same line as HCPCS code Q3014.

- Hospital inpatient, skilled nursing facility, home, or location determined appropriate by the individual receiving service: There is no payment to the originating site for the originating site facility fee in these settings.
- Critical access hospitals: When the originating site is a critical access hospital outpatient agency, payment is separate from the cost-based payment methodology. To receive payment for the originating site facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.
- FQHCs and RHCs: When the originating site is an FQHC or RHC, bill for the originating site facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter.
- Physicians' or other health professional offices: When the originating site is a physician's office, bill for the originating site facility fee using HCPCS code Q3014.
- Other settings: When the originating site is an approved telemedicine site, bill for the originating site facility fee using HCPCS Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telemedicine, documentation for both services must be clearly and separately identified in the client's medical record.

Distant site (location of consultant)

What is a distant site?

A distant site is the physical location of the health care professional providing the health care service to an eligible agency client through telemedicine.

What services are covered using telemedicine?

The agency reimburses medically necessary covered services through telemedicine when the service is provided by a Washington Apple Health provider and is within their scope of practice.

How does the distant site bill the agency for the services delivered through telemedicine?

The payment amount for the professional service provided through telemedicine by the provider at the distant site is equal to the current fee schedule amount for the service provided. Submit claims for telemedicine services using the appropriate CPT or HCPCS code for the professional service.

Use place of service (POS) 02 to indicate that a billed service was furnished as a telemedicine service from a distant site.

The agency discontinued the use of the GT modifier for claims submitted for professional services (services billed on a CMS-1500 claim form, when submitting paper claims). Beginning January 1, 2018, distant site practitioners billing for telemedicine services under the Critical Access Hospital (CAH) optional payment method must use the GT modifier. See the agency's [ProviderOne Billing and Resource Guide](#) for more information on submitting claims to the agency. See the agency's [Inpatient Hospital Services Billing Guide](#) for more information on billing for services under the CAH optional payment method.

Follow CMS guidance for modifiers if Medicare is the primary insurance.

Add modifier 95 (via interactive audio and video telecommunications system) if the distant site is designated as a nonfacility.

Nonfacility providers must add modifier 95 to the claim to receive the nonfacility payment.

For questions related to FPO telemedicine billing and claims, please email HCAFamilyPlanning@hca.wa.gov.